## IOAC Monitoring Framework for WHO/WHE

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<th>Subject of monitoring and assessment</th>
<th>Internal and external communication</th>
<th>External communication mechanisms and processes</th>
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| I. Key elements of the WHE Programme  | Management and administrative process | WHO leadership in global health: The thirteenth General Programme of Work (2019-2023) was adopted by Member States at the 71st World Health Assembly in May 2018. The GPW sets out three ambitious strategic priorities that will allow us to achieve the health-related SDGs. These are:  
1. Achieving universal health coverage – 1 billion more people benefitting from universal health coverage  
2. Addressing health emergencies – 1 billion more people better protected from health emergencies  
3. Promoting healthier populations – 1 billion more people enjoying better health and well-being |
| (Legacy from the previous IOAC)     | • WHO leadership in global health  
• Delegation of authority, accountability, reporting lines and decision-making processes among Headquarters, Regional Offices and Country Offices  
• Standardization across the regions of WHO Representatives’ financial authority to accept funds | The Emergencies Programme has three outcome measures that contribute to delivery of Strategic Priority 2. These are:  
2.1 COUNTRIES PREPARED FOR HEALTH EMERGENCIES  
2.2 EPIDEMICS & PANDEMICS PREVENTED  
2.3 HEALTH EMERGENCIES RAPIDLY DETECTED & RESPONDED TO  
Within each of these are a number of output measures that will allow the programme to track whether progress is being made. WHO’s capacity to rapidly deploy surge personnel to respond to the DRC Ebola Outbreak in May has significantly improved confidence from partners and donors in WHO’s leadership in health emergencies. Several new initiatives such as the WHE learning and capacity development initiative/unit, and the DG’s, global health emergency corps improved data analytics for preparedness, and the Global Preparedness Monitoring Board are expected to further enhance WHO leadership in global health emergencies. The WHE leadership team made up of the DDG, ADG, regional emergency directors and WHE HQ directors continually strengthens and demonstrates its effectiveness in building One Programme and ensure coherent work as a 3-level team.  
**Delegation of authority, accountability, reporting lines and decision-making processes among Headquarters, Regional Offices and Country Offices:** The SOPs for the Delegation of Authority (DOA) for emergencies were published in 2017. Further guidance on DOA implementation in GSM was released in 2018 in coordination with a corporate initiative to harmonize approval levels across Major Offices. Decision-making processes continue to improve with IMS structure consistently established for graded emergencies. Based on the feedback received, some revisions are being proposed including procedures to re-delegate responsibilities to others in the IMS depending on the context and the emergency. The challenges include inconsistent application of delegation of authority across offices.  
**Standardization across the regions of WHO Representatives’ financial authority to accept funds:** A harmonized template for WHO Representatives (WRs) Delegation of Authority is being implemented across all WHO major offices. DOAs to WRs for resource mobilization is being reviewed as a part of WHO Corporate Transformation, in which end-to-end Resource Mobilization processes are being discussed.  
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- **Internal and external communication:**  
  - WHO external communication mechanisms and processes including communication with Member States (grading, risk communication)  
  - Effectiveness of communication within the WHE programme across the three levels  
  - Consistency and coherence of corporate communications in relation to WHO’s Department of Communications and other programmes within WHO  
  Internal and external communication  
- **External communication mechanisms and processes:**  
  - WHO leadership in global health: The thirteenth General Programme of Work (2019-2023) was adopted by Member States at the 71st World Health Assembly in May 2018. The GPW sets out three ambitious strategic priorities that will allow us to achieve the health-related SDGs. These are:  
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2. Addressing health emergencies – 1 billion more people better protected from health emergencies  
3. Promoting healthier populations – 1 billion more people enjoying better health and well-being  
- **External communication mechanisms and processes:** The WHE communications team works closely with other communicators at all three levels of the organization. For each priority country facing an emergency, a communications strategy is developed with input from country and regional office communicators. Country communications officers are the main points of contact with MoH counterparts, either urging the ministry to communicate on a developing health issue (e.g. cholera in Zimbabwe), or jointly producing communication materials (e.g. DRC Ebola outbreak).  
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  - WHE uses the same communication channels as the rest of the organization, through the WHO country and regional web pages, social media accounts, and by reaching out to media directly. WHE will amplify Member State products, especially on joint actions (e.g. Uganda Ebola preparedness).  
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- **Communications within WHE across the three levels:** Communications across the three levels has been steadily improving. WHE Directors have biennial face to face meetings to review key strategic, programmatic and managerial issues of relevance for the Global Programme. Key themes have included delivering on GPW 13, monitoring and measuring impact, inspirational and accountable leadership and health systems in fragile, conflict and vulnerable settings.  

  - In addition, a weekly roundup of key activities across the programme is shared with all WHE staff. In addition, there are monthly teleconferences across the three levels with all the emergency directors. The Programme Area Networks also have regular video/tele conference and network meetings. The HQ senior management team meets weekly for information sharing, problem solving, decision making and accountability. The expanded senior management team (SMT+) meets monthly to build a broader team of managers and leaders who are well informed and part of decision making processes. In addition to the weekly Round Ups, the office of the DDG regularly shares relevant information and documents with all staff in HQ and the regional offices. The DDG holds quarterly meetings with all HQ staff.  
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**Consistency and coherence of corporate communications:** The WHE communications team works closely with DCO. We copy each other into correspondence with technical focal points, call and meet regularly, and share office space. DCO and WHE hold joint teleconferences with communications focal points in the regions at least monthly. WHE provides DCO with talking points on the key issues they are likely to be asked about, asking for their input to improve these. We develop social media messages together for senior leadership. The DDG tweets regularly on current events and issues of importance.

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<tr>
<th>Human resource planning, recruitment and retention of talent</th>
<th>Country business model:</th>
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<tr>
<td>• Implementation of the Country Business Model</td>
<td>the percentage of occupied positions at the country level has increased from 37% in October 2017 to 53% in October 2018. Progress in 2018 was initially delayed due to lack of funding, and subsequently delayed due to involvement of WHE teams in response activities.</td>
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<tr>
<td>• Selection, recruitment, training and deployment</td>
<td>IM selection, recruitment and training:</td>
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<tr>
<td>• Recruitment rate of WHE positions in Country</td>
<td>Recruitment rates: From Oct 2017 to Dec 2018, the number of occupied positions at HQ level has slightly decreased by less than 1%, at RO level increased by 32%, and at CO level by 48%.</td>
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<td>• Offices versus Headquarters and Regional Offices</td>
<td>Fast-track SOPs have not been systematically applied, as it was felt that the short announcement period did not allow the programme enough time to source qualified candidates, and there was a preference for temporary arrangements which were felt to be more rapid.</td>
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<td>• Systematic application of fast-track standard</td>
<td><strong>Mobility:</strong> WHO’s geographic mobility policy becomes mandatory in the fourth quarter in 2019. The functional networks of human resources (i.e. staff with the same title and job description across a number of geographic locations) will facilitate the application of rotation and mobility within WHE.</td>
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<td>• operating procedures (SOPs) and contract</td>
<td>Provision of incentives: WHE is working with HRD to pilot incentives to encourage staff to take positions in hardship duty stations, including one grade increase and conversion from temporary to fixed-term positions. Within the overall context of WHO Transformation Implementation, WHO Health Emergencies Programme will work closely with the Business Operations Pillar (largely composed of the previous GMG) in this area.</td>
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<td>• WHE staff rotation policy in the context of WHO geographical mobility</td>
<td><strong>WHE Finance</strong></td>
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<td>• Provision of incentives to attract/retain high calibre staff in hardship duty stations</td>
<td>The WHE fundraising strategy continues to be based on three principles:</td>
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<td><strong>Country business model:</strong></td>
<td><strong>Sustainability (WHE needs both quantity and quality of funding and a broader donor base);</strong></td>
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<td><strong>Selection, recruitment, training and deployment</strong></td>
<td><strong>Integration</strong> the (RM component goes hand-in-hand with the communications and advocacy components of WHE overall EXR strategy); and**</td>
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<td><strong>Retention of talent</strong></td>
<td><strong>Dynamism</strong> (progress towards achieving the targets needs to be regularly reviewed, and the strategy adjusted accordingly).**</td>
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<td><strong>Human resource planning, recruitment</strong></td>
<td>The RM strategy has three pillars, which align with the corporate RM strategy developed for WHO in early 2019:</td>
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<td>and retention of talent**</td>
<td><strong>Institutional donors</strong> (over the course of 2017 and 2018 WHE has been deepening the relationship with existing major donors and reaching out to emerging donors). WHE has been focusing on the following major existing donors: Australia, Canada, EU, Germany, Japan, RoK, UK, UN, US, and the World Bank, and broadening the engagement with Nordic countries (Norway, Sweden), BENELUX, France, GCC (Kuwait, UAE, KSA), BRICS (China, Russia, India).</td>
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<td><strong>Professional development</strong></td>
<td><strong>Foundations:</strong> WHE has been deepening the relationship the King Salman Aid &amp; Relief Centre and, in cooperation with CRM, working to deepen and consolidate the partnership with the Bill &amp; Melinda Gates Foundation and the Wellcome Trust.</td>
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<td><strong>Retention of talent</strong></td>
<td><strong>Emerging and innovative streams:</strong> WHE has been tapping into new opportunities such as RoK’s Global Disease Eradication Fund.</td>
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<td>• WHE fundraising strategies</td>
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<td>• Resource mobilization capacity at country level:</td>
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<td>level and effectiveness of engagement of WHO</td>
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<td>• WHE donor portfolio and multiyear partnerships</td>
<td>Individual donor engagement plans have been developed for the top ten donors, detailing budget cycles, financial targets and key dates/events and matching WHE activities/projects to areas of interest for 2018. These are being revised and updated in 2019. As regards OCR and CFE funding, WHE has continued to target humanitarian funding and is strengthening country-level capacity to tap into country-based pooled funds such as CERF funding. WHE rolled out a CFE replenishment strategy in 2018 and is revisiting this in 2019; the CFE attracted more than US $38 million in 2018 and from 13 donors, of which seven were new donors. As of March 2019, commitments towards the CFE stand at some $ 27 million.</td>
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<th>Partnership and Coordination</th>
<th>Resource mobilisation at country level: The CBM includes plans to increase resource mobilization capacity at country level and recruitment is underway. Dedicated resource mobilization officers are in place in seven of ten WHE priority countries (Democratic Republic of Congo, Ethiopia, Nigeria, Somalia, South Sudan, Syria, Yemen), with temporary arrangements in the remaining four countries (Afghanistan, Iraq, Mali). In 2019, it is expected that all ten WHE priority countries will have dedicated resource mobilization officers in place.</th>
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<td>• Engagement and support to</td>
<td><strong>WHE Finance</strong></td>
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<td>the Global Health Cluster</td>
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Partnerships are an essential part of our collective ability to prepare for, prevent, detect and respond to health emergencies. The WHO Health Emergencies Programme works across a number of different technical networks to support delivery. In terms of response, the WHE programme is working to optimize the synergies and complementarity amongst these mechanisms as part of our work towards having a Global Health Emergency Corps that would allow us to leverage capacity across the world. Below we consider three critical partners: the Global Outbreak, Alert and Response Network and the Emergency Medical Teams we are able to maximise our capacity in responding to humanitarian needs.
Global Health Cluster: Since the last report, six new partners have joined the Global Health Cluster (GHC), increasing membership to 55 organisations. Two are classified EMTs and their direct engagement in the GHC will foster inter-network relations and expertise on thematic issues including quality assurance. The international partner capacity mapping exercise was delayed from late 2017 until mid-2018. The survey has been completed and final report due in November 2018. Planning to undertake the national partner capacity mapping exercise has started.

In four regions (AFRO, EMRO, EURO and SEARO) the Operational Partnership Lead posts, established as part of the Country Business Model, are increasingly providing direct support to their respective health clusters to support the roll-out of IASC and GHC policies and guidance. The GHC unit is supporting EMRO to host their first regional cluster meeting in November 2018 and is supporting SEARO to plan and deliver a regional Health Cluster Coordination training in May 2019. These activities support WHO and partner capacities to implement more contextually appropriate response.

The GHC has contributed to the L3 outbreak protocol revision. Operationally, the cluster is adapting its role at country and global level as WHO strengthens its leadership role in outbreak response including the more systematic application of Incident Management System and activation and/or support to EOCs. Whilst the ‘pillared approach’ to outbreak responses brings substantial benefits to plan and coordinate the response, the interface with existing health cluster/sector partners continues to present some challenges in respect of recognising their presence, capacities and comparative advantages particularly to access hard-to-reach areas. Partners & donors have been pro-actively engaging with WHE to overcome these barriers and enable closer engagement and are requesting clear guidance on this interface which has yet to be developed but planned.

As of Sept 2018, 19 out of 27 (70%) country health clusters/sectors have dedicated Health Cluster Coordinators at national level (69% in 2017). This includes nine out of 10 Priority 1 countries (Afghanistan, Bangladesh, DRC, Iraq, Nigeria, South Sudan, Somalia, Syria & Yemen). Eight clusters (30%) have part-time/double hatting national level coordinators. Several recruitment rounds have been undertaken /are ongoing by Regional Offices to identify suitable candidates for the outstanding dedicated posts, however in some instances this process is overly protracted (Ethiopia) or suitable candidates applying for WHE and HCC positions are appointed to the former position.

Securing Information Management Officers continues to be challenging – currently only 12 (44%) of clusters have dedicated IMOs most hired on short term contacts linked to event based funding or deployed through Standby Partners. Nine clusters (33%) have part time/double hatting IMOs and 6 clusters (22%) have no IMO. As part of the WHE Country Business Model, steps are being taken to harmonise the currently siloed IM capacity within WCOs to more effectively use existing resources, but additional IM skills/capacities are still needed to address current gaps. A proposal to develop a multi-agency consortium approach to strengthen WHE-HIM capacity to support WHO and Cluster operations was submitted to WHE in Q3 2017 and protracted negotiations are ongoing between WHO-HIM and LSHTM (consortium lead). In addition, the strategic partnership with IMMAP is being strengthened at global and regional (EMRO & AFRO) level to enhance country capacity.

The original global HCC network recruited between Q4 2016 & Q2 2017 currently accounts for 55% of current HCCs. New HCCs have been recruited since then through a series of regional selection processes.

HCC performance remains variable. The HCC network management proposal developed by the GHC & MGA and submitted to PAMS and REDs for consideration has not been adopted.

The GHC delivered 2 face to face joint HCC-IMO trainings to 47 participants in July and November 2017, the latter being the first Francophone training, for all AFRO clusters. Overall, 111 people have completed the Health Cluster Coordinator Training since 2015. The next joint training will take place in November 2018, targeting 48 participants. Development and launch of the HCC E-learning program has been delayed due to GHC team deployments. The HCC mentoring pilot was completed in July 2018.

The GHC unit is supporting WHO HCC roster development through technical screening. Initial review of candidates suggests a mismatch between the number of people undertaking HCC training and those being proposed to be part of the roster. This imbalance needs to be rectified to ensure training investments are allocated to a cadre of high performing HCCs.

The Global Outbreak Alert and Response Network

- From 1 October 2017 until beginning of November 2018, 161 experts from 41 GOARN Partners institutions were deployed to support response to 13 operations in 13 countries.
- 3 GOARN Outbreak responses trainings were organized in this reporting period (Philippines, Oct. 2017; Australia, Oct. 2017; Congo, April 2018) with a total of 72 experts from GOARN partners institutions trained (24 experts in each training).
- Two GOARN Steering Committee (SCOM) Meetings took place in this reporting period (SCOM meeting #22, 4 and 8 December 2017 in Geneva, SCOM meeting #23, from 20 – 21 June 2018, organized in collaboration with UNICEF in New York).

Both meetings provided a forum to review progress in the areas of work, further develop strategy, assess responses to public health emergencies which involved GOARN partners and update the roadmap of GOARN activities.
• Global Meeting of GOARN Partners took place from 5 – 7 December 2017 in Geneva. More than 100 network partners from across the world participated in the meeting, including representatives of government organizations, hospitals, international organizations, network hubs, nongovernment organizations (NGOs) and academic institutes. The objective was to make the network more effective in utilising the expertise of partners in supporting countries to prevent and control disease outbreaks and public health emergencies and inform further development of GOARN 2.0.
• GOARN Weekly Operational calls have been instituted on 27 January 2017 and have been running on the regular basis since then, with participation of the GOARN SCOM members and key operational partners. Weekly Operational calls provide a forum to share information about acute events with key partners, and support coordination of response activities.

The Emergency Medical Team (EMT) Initiative focus over the past year has been training and capacity building of national medical response teams;
- More than 118 countries are aware of the EMT Initiative, with over 60 countries hosting national awareness workshops.
- 32 countries have active EMT capacity strengthening processes ongoing, with direct support from WHO, while another 25 countries are starting this process.
- 8 regional EMT Coordination courses and 22 national EMT coordination courses ran to train experts in national response team coordination and international request and coordination systems under national Health EOC structures.
- More than 12 regional and international simulation exercises held with specific participation by EMTs and supported through the EMT Initiative.
- 21 teams have completed a quality assurance process, been successfully been classified and placed on the WHO directory of internationally deployable EMTs. 79 other teams are in the mentorship process and receiving direct support to reach the minimum standards to achieve classification.

Using the nationally led coordination approach, several countries have been able to coordinate medical team responses to emergencies such as Indonesia (Sulawesi earthquake 2018), Philippines (Typhoon Mangkhut 2018), Colombia and Ecuador in the context of the Venezuelan migrant crisis, and Palestine (humanitarian situation due to the mass demonstrations).

WHO continues work to set global standards for EMTs through consultation at regional and global level on updates to the Classification and Minimum standards for Emergency Medical Teams (also known as the “Blue Book”), the initiation of the drafting process of the guidance document on the engagement of EMTs in conflict settings (known as the “Red Book”). Final drafts of the minimum standards and recommendations for EMTs on maternal, new-born and child health as well as on burns care have been developed and a technical working group on clinical care in highly infectious disease outbreak settings is set to start in early 2019.

The work of the EMTs has been endorsed by the WHO Regional Committee for South East Asia recently adopted Resolution SEA/RC71/RS om “Strengthening Emergency Medical Teams in the South East Asia region”, and the European commission’s implementing decision (EU) 2018/142 “Emergency medical teams (types 1, 2, 3 and specialised care) are considered certified if they have undergone the verification process of the World Health Organisation (WHO). The registration and certification procedure of emergency medical teams in the EERC shall complement the WHO verification process.”

Lastly, four out of six WHO regions have fully established their regional EMT governance platforms, which are the main forum at the regional level allowing for Member States, EMTs and other stakeholders to shape, guide and drive the implementation of the EMT Initiative in their region. Concerted efforts were made to strengthen the Standby Partnerships from August 2017 onwards, increasing deployments by 75% in 2018. 60% of these deployments were for the country support functions while 40% of these were for the Health Cluster.

Some of these included:
1. Raising awareness amongst the regional and country teams especially in priority emergency countries e.g.: Somalia, Kenya and DRC and regions ego: EURO, AFRO, SEARO and EMRO.
2. Proactively reaching out to some countries for possible options to support with deployments for the emergencies.
3. Coordinating with DFID – SBP, UK, to seek funding support for partners for deployment for EBOLA response in DRC and EBOLA preparedness to Rwanda and South Sudan.
4. Nearly 30 deployments were done in Bangladesh, Cox Bazaar and 15 in DRC.
5. 2 new partnership agreements were signed up with the Government of Iceland and with UK-Med.

WHO has reinforced its coordination with the Inter-Agency Standing Committee in several ways:
- A 3-days simulation exercise was organized by WHO in December 2017 testing the IASC L3 infectious events protocol in simulated conditions of a real event (scenario: severe air-borne new respiratory disease with high fatality rate in a remote mountainous border area of South East Asia). This simulation an escalated approach from technical, to directors, to Principals level cumulating towards a simulated meeting of IASC heads of agencies to take decision on activation of the protocol and related urgent actions to be taken by the system.
- In follow-up to this simulation, lessons were collected on the protocol and WHO has revised the protocol which was shared with IASC Emergency Directors for review in November 2018.
I. Issues requiring corporate-level solutions (WHO Transformation Agenda)

| Procurement and supply chain management                                      | Benchmarking: Benchmarking exercises were conducted by WHE/OSL in June 2017 and are also relevant within the context of the WHO transformation business process re-design. The current proposal is to reduce lead time from an average of 173 days to 49 days. WHE is heavily engaged in the supply chain business process re-design work, which will initially focus on five immediate initiatives (Developing categories for standard requirements of goods covering 80% of spend; development of standard procurement lists for emergencies working with EMRO; development of Warehouse SOPs; Annual import plans and; design of a control tower to oversee stock management). In addition, OSL are in discussions with the World Food Programme (WFP) to develop operational service level agreements to capitalise on the strength of WFP’s logistical capability including Camp/Life Support, Surface Transport, Communications, Air Transport, and EOCs. OSL is also exploring additional operational partnerships and service level agreements with other UN agencies and implementing partners.
| Corporate strategy and investment level                                      | As part of the WHO Transformation agenda, the General Management (GMG) and departments across WHO including the WHE Health Emergency Programme (WHE) are collaborating on building a fit-for-purpose supply chain that will support WHO programmes and initiatives as well as provide the necessary supply chain support for health emergencies.
|                              | Emergency measures under the Framework of Engagement with Non-State Actors | Emergency measures under the Framework of Engagement with Non-State Actors have been published on eManual XVII. In order to accelerate the engagement in a timely manner to support critical emergency response situations, a number of options exist. A decision tree and self-assessment checklist have been developed to guide responsible officers through application of the FENSA requirements in the context of emergency response. FENSA focal point in the regions will play a key role in facilitating the process.
| Security and staff protection                                                 | Corporate strategy and investment level: The recruitment is in progress of a WHO Director of Security Services, whose function it will be to establish a Service that is fit for purpose for WHO’s needs and requirements, including the WHO corporate strategy for security, as well as related requirements and investments. This will include the development of a 5-year strategic plan that will encompass all needs. This is further complimented with the ongoing recruitment processes of a Security Coordinator (PS) and a Security Officer (P4) positions. In addition, two security officers have been recruited on temporary contracts (1xP3 and 1xP4), specifically to bolster the security support in the current EVD response in DRC.
| Corporate strategy and investment level                                      | WHO security function in emergencies: WHO is fully part of the UN Security Management System (UNSMS) and fully engaged in the Inter-Agency Security Management Network (IASMN), which translates to full integration and coordination with UNDSS in emergencies, as well as day to day functionalities at all levels (i.e. strategic, operational and tactical security management).
| Adequacy of procedures and measures for protection of staff and deployed experts, including medical evacuation | Adequacy of procedures and measures for protection of staff and deployed experts, including medical evacuation: Procedures and measures exist within WHO, as part of the UNSMS, to provide adequate protection to staff and experts. Opportunities remain to improve preparedness of staff, enhanced frameworks and related procedural components, equipment, awareness and compliance. This is in the process of being addressed and remains a priority focus to ensure a sustainable and functional security apparatus within WHO.
| Field application of WHO’s policy for prevention of and response to sexual harassment, sexual exploitation and abuse | Field application of WHO’s policy for prevention of and response to sexual harassment, sexual exploitation and abuse: More than 90% of WHE staff completed the mandatory training. The consequences of non-compliance are followed based on WHO Mandatory Training Policy within annual performance management cycle. This policy is also included in the draft WHE Global Surge Policy.

- For the two Ebola outbreaks in DRC of 2018, WHO decided not to activate the IASC protocol but is nonetheless coordinating very closely with IASC and UN partners, with coordination meeting held at IASC Principals level by DG and WHE DDG, briefings organized for DG to the UN Security Council culminating into resolution 2439 unanimously adopted by the Council on 30 October 2018 urging Ebola responders’ safety in DRC. DG also briefed jointly with DPKO Principal the UN Chief Executive Board (CEB) in November 2018. In addition, WHO is coordinating the Ebola response in DRC actively with IASC Emergency Directors (weekly to bi-weekly teleconference organized for Ebola coordination with all IASC Emergency Directors).
- WHO also improved its engagement with the UN Crisis Management Group. WHO participated in 2018 in the UN stock-taking of the implementation of the UN Crisis Management Policy and is leading the development of a simulation exercise around this mechanism for a health crisis. WHO is recognized as UN lead Agency for health crises if the UN Crisis Management Policy is activated with delegated authority from the UN Secretary General for UN coordination of the response.
- Finally, WHO is an active member of the IASC beyond infectious events responses: in particular WHO coordinated certain aspects of the revision of the standard IASC response scale-up protocol revision and co-chaired the IASC task team on the humanitarian and development nexus (central IASC body for work in fragile, conflict-affected and vulnerable countries).
- WHO routinely submits memos to the UN secretary General regarding acute public health events that are high or very high risk at regional or global level as was done recently in the two outbreaks of Ebola virus disease in the DRC.
- WHO DG spoke at the meeting of the SG and his senior management group about the management of infectious disease events and lessons learned.
A Global Surge Policy is in the final stage of revision and will be presented to GPG and DG for decision. The draft policy aims to improve WHO’s corporate capacity to surge during emergencies by stipulating some enabling policy provisions such as availability for emergency deployment as a requirement for WHE employment, supervisors to be supportive for the release of staff, flexible entitlement during deployment, etc.

Partnership roster SOPs as well as Guidelines on selection & request for deployment are in the final stage of development.

Procedures for Medical Evacuation for non-staff are published. A key component of the newly published SOPs is to have WHO ensure up-front arrangements and financing is provided and then recover costs to the furthest extent possible afterwards. The detailed SOPs for provision of medevac by WHO for partner agencies is being developed.

Administrative Services for Emergencies have been updated to align with the revision of activation of emergency SOPs, including streamlining the authorized officials to request emergency services in GSC. GSC has updated the Emergency on-call list for a variety of administrative services for graded emergencies.

In line with WHO corporate FENSA policy, engagement of non-state actors during emergencies was published, outlining the simplified procedures to obtain approval to engage non-state actors (see section “Procurement and Supply Chain Management”)

Finance: Consultant payment modality procedure is fully operational after GSM enhancement. Since April 2018, monthly travel request is no longer needed to generate consultant payment. Consultant contract consists of simplified single allowance and lump-sum for incidental cost.

In line with CFE Replenishment Strategy, the key principles on how to request and management of CFE are further circulated to all country offices to further understanding of CFE management, especially on reimbursement of CFE.

Cost Recovery Policy is under development and is being streamlined into WHE Resource Mobilization Strategy. The key principles under discussion include: ensure all staff and running costs required to implement projects are included in proposals.

**III. WHE Programmatic areas**

1. *Preparedness for health emergencies*

   **Health emergency preparedness in countries, including implementation of IHR**

   - All-hazards emergency preparedness including IHR core capacities assessed and reported
   - National Action Plans (NAPs): timelines for development and implementation, funding and technical support from WHO and its partners
   - Review of assessment tools such as Joint External Evaluations (JEEs)
   - Minimum core capacities for emergency preparedness and disaster risk management established in all countries
   - Countries and WCOs operationally ready to manage identified risks and vulnerabilities
   - Strategy for IHR capacity development in fragile states
   - Link between WHE and other relevant programmes within WHO, in particular health care systems
   - Scale down of IMS and transition process following major events to build national capacities on lessons learnt in a sustainable way

   WHE is working closely with Member States to assess capacity gaps and the development and implementation of national action plans to strengthen country capacities for manage the range of risks they face. WHE is working across WHO programmes to ensure this work is integrated within an overall approach to health systems strengthening, that best practices are shared and applied, and that community engagement is a component of all national capacity strengthening plans. Capacity gaps are identified, and capacity strengthening is measured through IHR reports, independent assessments, simulations and after-action reviews and other forms of assessment. Emergency preparedness is being implemented with MS and in WCOs to establish minimum capacities, as well as operational readiness as required by ongoing events and early warnings. WHO continues to work with Member States and partners to strengthen the coherence between the implementation of the SDGs, Sendai Framework for Disaster Risk Reduction, IHR and other global and regional frameworks.

   **All-hazards and IHR core capacities assessments and reports:**

   - As of 1st March 2019, 92 countries have volunteered for a Joint External Evaluation; 97 Simulation exercises have been done (including country level and regional and internal exercises) and 45 After Action Reviews conducted. 21 IHR-PVS National Bridging Workshops have been organized in MS countries to encourage the contribution of the veterinary sector in the implementation of the IHR (2005).
   - As of 28 February 2019, deadline for States Parties to submit their annual reports, 171 (87%) of State Parties of all Regions have send reports to the Secretariat to report to next World Health Assembly in May 2019. WHO is supporting State Parties in all levels of the Organization to increase high quality reporting to WHA. The information received is being used to track progress against frameworks for public health. This includes the UN’s Sustainable Development Goal 3 and the WHO’s Thirteenth General Programme of Work (GPW 13).
   - The FAO-OIE-WHO (Tripartite) guidance document “Taking a Multisectoral, One Health Approach: A Tripartite Guide to Addressing Zoonotic Diseases in Countries” (also referred to as the Tripartite Zoonoses Guide) has been cleared by the three Organizations and will be published by the 8th of March. The guide aims at supporting national implementation of multisectoral, One Health approaches for a variety of topics and associated TZG Operational Tools. The first tool that has been developed id the Joint Risk Assessment (JRA) which has been piloted in 3 countries.

   **National Action Plans (NAPs):**

   - Since 2016, 48 NAPHS have been completed (21 in AFRO, 13 in EMRO, 2 in EURO, 5 in SEARO, 6 in WPRO and 1 in PAHO).
   - A NAPHS toolkit was developed to support the planning of priority actions and to cost those actions using national standards. The toolkit includes a WHO guidance on Benchmarks for IHR capacities to guide the planning process.
• The NAPHS Framework to support the health security planning in countries based on country risk profiles and capacity assessments was revised and published: https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.52/en/. In addition, a Country Implementation Guide to operationalize the NAPHS framework is finalized and will soon be published.

Review of assessment tools:
• WHO has published the IHR Monitoring and Evaluation Framework (IHRMEF) which comprises of the four components (State party annual reporting, voluntary external evaluation, after action review and simulation exercise): https://www.who.int/ihr/publications/WHO-WHE-CPI-2018.51/en/
• The AAR Manual is finalized and will be soon published. An introductory course on simulation exercises is available on the OPENWHO platform: https://openwho.org/courses/simex, while the AAR e-course is currently under development. In addition, WHO has been conducting regional trainings on the planning and management of Simulation exercises and after-action reviews. In total 8 regional trainings have been conducted, where a total of 221 individuals have been trained, including staff from MoH, WHO and partners.
• WHO has developed a Resource Mapping (REMAP) tool to support Member States to identify activities that are already funded as well as the technical assistance provided by partners. REMAP contributes to better alignment and harmonization of the work between governments and partners. It can also be used as a monitoring tool to follow-up on the implementation of plans at country level. Resource Mapping workshops have taken place in Sierra Leone and the United Republic of Tanzania.

Minimum core capacities established in all countries:
• The results of multiple country capacity assessments are being analysed with the objective of presenting comprehensive pictures of national capacities to Member States and partners.
• As recommended in the IHR 5-year strategic plan, development of a global National IHR Focal Points Knowledge Network / Community of Practice is ongoing. This will support functioning of regional knowledge networks, facilitating the exchange of experiences and lessons learned between NFPs, based on regional and common areas of interests / challenges faced (small island countries, south-to-south cooperation, etc.)
• WHO has provided guidance on the workforce development of the National IHR Focal Points and IHR implementation, including Orientation to the IHR, Senior Government Leaders, dissemination of WHO validated learning packages on the IHR (the IHR Training Toolkit and IHR related MOOCs). Testing of the functionality of national capacities in preparing for, detecting and responding to a public health event is ongoing through an online gaming situation, “The IHR Serious Game”
• Regional and sub regional Technical trainings have been organized to provide SOPs for prevention, detection and event management at Points of Entry (ports, airports and ground crossings) in WHO/AFRO countries, including vector surveillance and control. A number of meetings have been held in countries, e.g. in Pakistan and Iraq to map hazards and develop a public health preparedness and response plan in the context of mass gatherings. Cross border collaboration meeting to enhance surveillance and response in the context of mass gatherings have been also convened between Iraq and the neighbouring countries (Jordan, Bahrain, Kuwait, Qatar, UAE, Oman & Iran)

Countries and WCOs operationally ready to manage identified risks and vulnerabilities
• WHO works with governments to identify potential and anticipated risks using standardized tools such as Strategic Tools for Assessing Risks (STAR), Vulnerability Risk Assessment and Mapping (VRAM), and where necessary, accelerate readiness activities for emerging or anticipated events. Since 2016, 47 risk profiling workshops were conducted with the support of WHO, most of which took place in the African Region. An operational readiness tier one online training is now available on OPENWHO: https://openwho.org/courses/operational-readiness-introduction

Using information from risk assessments, early warning, the JEEs and other sources, WHO and MS are identifying priority public health risks and the capacities required to manage them. Based on this WHO is supporting countries to strengthen operational readiness including contingency plans. This was done in the context of the Ebola outbreak in the Democratic Republic of Congo and in 10 countries neighbouring DRC. WHO and partners have supported these countries to enhance their readiness for the potential spread of EVD across a set of key capacities, including coordination and leadership, epidemiology and surveillance, laboratory support, case management, infection prevention and control, vaccines, points of entry, risk communication and community engagement. WHO has also mobilized human and financial resources to enable countries, partners and WHO to support country readiness for EVD.
Strategy for IHR capacity development in fragile states

- WHO is developing a guidance document on conducting JEEs and developing and implementation of NAPHS in special context countries, including countries in conflict. A technical meeting was held in Geneva in December 2018 and the draft guidance has been updated.

- In addition, WHO works directly and indirectly with countries to build their capacity to meet IHR core capacity requirements.

- One example is WHO's work to provide financial, human resource, logistical and quality assurance support to build public health laboratory systems and networks to provide essential data to inform and monitor disease control strategies. This support helps progress efforts towards sustainable biosafety/security policies and measures including in collaboration with animal sector to strengthen policy dialogue with financial and technical partners, non-state actors, other international organizations and Member States and provide strategic and technical support to develop national public health laboratory systems. Work is ongoing to develop the WHO/USCDC/ECDC/FAO/OIE/APHL Global Laboratory Leadership Programme.

- WHO has supported the setup of national Rapid Response Teams in low-resourced and vulnerable countries in particular throughout AFRO.

Link between WHE and other relevant programmes within WHO, in particular health care systems

- Mechanisms for strengthening collaboration between WHE and other parts of WHO working on health system strengthening have been put in place. There are two weekly meetings between the Deputy Director General of the WHE programme and Deputy Director-General for Programmes to oversee progress on implementing work to strengthen health systems in fragile, conflict and vulnerable settings.

- WHE conducted a workshop with multi-stakeholder stakeholders in November 2018 to review and finalise the Health Emergency and Disaster Risk Management (Health EDRM) Framework, the WHO Glossary for Health EDRM, and technical guidance notes to Ministries of Health for monitoring and reporting of the health-related targets and indicators for the Sendai Framework for Disaster Risk Reduction.

- WHE has developed a draft framework on Leveraging Health Systems for Health Security and a global expert consultation will take place on 6-7 March in Geneva. The framework aims to i) Lay out key considerations for leveraging health systems for health security; ii) Identify elements that constitute preparedness capacity across different levels of maturity of the health systems and iii) Provide a methodology to estimate cost for financing the health systems for health security

- At HQ, a joint scope of work around UHC in FCVs has been developed and discussions between HSS and IHR core capacity building are continuing. The key objective for this collaboration at HQ is to better align support to Regional Offices and Country Offices initially focusing on a small number of countries.

- At regional level, EMRO has strengthened collaboration between HSS and emergencies as part of their Health Systems and Emergencies Laboratory (HSEL).

- In Nigeria work is ongoing to implement the Humanitarian Development Nexus (HDN), joint support has been given to support the delivery of essential package of health services in Yemen and to strengthen pharmaceutical systems in CAR.

- A call has been arranged between HQ and regional and country offices to agree some concrete next steps in rolling out the protocol.

Scale down of IMS and transition process following major events to build national capacities on lessons learnt in a sustainable way:

- There is a clear process for scaling down the IMS and using learning to build national capacity sustainably. Following outbreaks of Plague in Madagascar, Ebola in Eastern Equateur province of the Democratic Republic of the Congo and Cholera in Zimbabwe a joint operations review was used to help guide the transition from acute event management to more sustainable learning. Transition activities included enhanced surveillance and retention of response capability. An After-Action Review helped identify key lessons and assist in risk mapping. Work is ongoing to strengthen the use of available data in defining risks and priorities.

2. Epidemics and pandemics prevented

- Research agendas, predictive models and innovative tools, products and interventions available for high-threat health hazards
- Proven prevention strategies for priority pandemic/epidemic-prone diseases implemented at scale
- Mitigate the risk of the emergence and re-emergence of high-threat pathogens

Research agendas, innovative tools and interventions

- Research agenda have been finalized for MERS-CoV, Zika virus disease, influenza and smallpox, and in development for Crimean-Congo haemorrhagic fever (CCHF), and roadmap developed for Ebola virus disease, Nipah virus infection, Marburg virus disease and Lassa fever.

- The Research and Development Blueprint work is continuing. The list of priority diseases for the blueprint was revised in 2018 including disease X. The work of the Blueprint has allowed the introduction of 4 new therapeutics for case management and large-scale vaccination against Ebola in the Democratic Republic of the Congo (DRC) Eastern Equateur and North Kivu. More than 80,000 high-risk people have been vaccinated. In addition, modelling work by the WHO CC Imperial College has been used to support and guide the response.

- The GeneXpert technology was used in DRC to allow rapid diagnostic field capacity: >13,555 samples tested.

- There have been significant improvements in clinical care during the Ebola outbreaks with a paradigm shift from isolation to care, and implementation of randomized control trials with new drugs during the Ebola North Kivu outbreak especially.
Stronger Risk Communication and Community Engagement (RCCE) with improved collaboration with partners (UNICEF, IFRC, and universities), the creation of a social science platform and the first-time ever publication of the WHO Guideline for Emergency Risk Communication policy and practice.

Rapid transfer of knowledge to front-line responders has been enabled with >100,000 subscribers to OpenWHO with 18 knowledge packs, 56 courses; and the successful publication of the Managing Epidemics handbook (downloaded >16,000 times in 6 months).

The Strategic & Technical Advisory Group for Infectious Hazards (STAG-IH) has been established and convened with 2 face-to-face meetings and 3 telephone conferences. TOFs have been finalized, and bi-weekly newsletters shared since November. STAG-IH is a global advisory group comprising 13 members, providing independent recommendations to WHO on infectious hazards that may pose a potential threat to global health security, and technical and scientific advice on issues related to the Pandemic Emergency Financing Facility (PEF) and the Global Preparedness Monitoring Board (GPMB). In 2018, the group provided independent informal expert advice on strategies to contain the two Ebola outbreaks in DRC and recommendations on whether to convene the Emergency Committee.

Other innovations in the pipeline include a potential antiviral for Monkeypox and discussion on global mechanisms for access and benefit sharing (influenza and beyond).

A demonstration tool to forecast cholera epidemics has been successfully developed. This tool can be used to improve preparedness of countries against recurring outbreaks.

Prevention strategies
The Secretariat develops global strategies for the prevention and control of epidemic-prone diseases, together with partners from a wide range of fields to bring together all globally available resources and scale these strategies to the regional and country levels, protecting billions of people.

CHOLERA: the “Ending cholera, a global roadmap to 2030” was adopted by the WHA in May and by the Regional Committee for Africa in October. Eight additional countries actively engaged in the global roadmap, and 20.8 million doses vaccines were shipped to 10 countries, including in complex emergencies settings such as Yemen with >725,000 vulnerable people protected.

YELOW FEVER: the “Eliminate yellow fever epidemics (EYE) 2017-2026” strategy was launched in the African Region in Nigeria in April; 27 country profiles to assess risks and guide EYE roll out were developed, and 61 million people vaccinated against yellow fever in 24 African countries.

INFLUENZA: the “Global strategy for influenza 2018-2030” has been finalized, following consultation and >50 Member States commentaries. In 2018, it has been estimated that more than 500 million people have been vaccinated against seasonal flu. In additional, through the Pandemic Influenza Preparedness (PIP) Framework, >400 million doses of pandemic vaccines and 10 million antiviral treatment courses are secured in case of a pandemic. Since 2012, over $169 million in Partnership Contributions (PC) have been collected to support capacity building. In 2018 alone, 72 countries strengthened national preparedness capacities. Additional impact is foreseen at the country level with the PIP PC High Level Implementation Plan II, published in 2018, and outlining the use of the funds until 2023.

MENINGITIS: the “Defeating meningitis by 2030” was drafted, with a first meeting of the Technical Task Force held in July. Strategic orientations have been defined.

In addition, WHO is also the Secretariat for the governance of global emergency stockpiles, including the International Coordinating Group (ICG) on vaccine provision. Through the ICG mechanism, WHO deployed 16 million of doses of vaccines for emergency vaccinations, saving millions of lives. In 2018, the Accountability Framework was adopted by all partners (GAVI, UNICEF, UNICEF SD, MSF, IFRC), endorsing the need to continue the ICG, after 20 years of providing life-saving vaccines in disease outbreaks.

Emerging and re-emerging diseases: support to prevention, risk assessment, preparedness and response

EBOLA: deployment of expertise to support the Ebola outbreaks in DRC, including updated strategy for laboratory; clinical management and therapeutics; infection prevention and control; vaccination and survivor programme; community engagement and safe and dignified burials.

LASSA: important outbreak with 633 confirmed cases, including 17 deaths in Nigeria. Rapid response and excellent leadership of the country with the organization of the 1st international Lassa fever conference in January 2019.

MERS-CoV: the “Global Prevention and Response Plan for Emerging Respiratory Diseases including MERS” has been finalized and significant improvements have been realized in surveillance and response (1 case in Korea with no further transmission).

PLAGUE: development of 3 technical documents for addressing plague outbreaks in Madagascar (treatment, surveillance and rodent control).

ZIKA: important steps in the technical agenda bringing together various partners to improve diagnostic and surveillance as well as vector control strategies in developing countries.

3. Detection and response to 2019/2020 emergencies (acute and protracted emergencies)

Potential health emergencies rapidly detected, and risks assessed

Application of Emergency Response Framework (ERF): risk assessment and situation analysis, WHO grading, Incident Management System (IMS), response procedures, roles and responsibilities

From 1 January until 31 December 2018, a total of 91 Disease Outbreak News (DONs) were posted (http://www.who.int/csr/don/archive/year/2018/en/)

Number of risk assessments total for 2018 & 2019 to-date (1 January to 31 December 2018, 63; 1 January 2019 to 4 March 2019, 12)

Number of events created in EMS: 1 January to 31 December 2018, 484; 1 January 2019 to 4 March 2019 94 events

WHO provided support for the enrolment of Public Health Information Services (PHIS) standard products in 16 Health Cluster Activated Countries. Among these countries, as of October 2018, 10/16 are implementing Public Health Situation Analysis (PHSA), 9/16 are applying the Early Warning Alert and Response System (EWARS), 6/16 have a Mortality Estimation in place, 8/16 have a Surveillance System for Attacks on Health Care running, 12/16 are systematically producing a Who does What and Where mappings (3W), 9/16 are using Partner list, 10/16 are implementing Health Resources and Services Availability Monitoring (HeRAMS),
- Acute health emergencies rapidly responded to, leveraging relevant national and international capacities
- Effectiveness of field operations
- Rationalization/standardization of production and dissemination of situation reports and risk assessments for each event
- Support affected countries for risk communication and community engagement
- Essential health services and systems maintained in fragile, conflict and vulnerable settings; working jointly between WHE and HIS

3/16 have activated a Health Information Management System, 4/16 are utilizing a Vaccination Coverage Estimation, 6/16 are implementing an Operational Indicator Monitoring, and 11/16 produce Health Cluster Bulletins on a monthly basis.

- In cooperation with MoH DRC, WHO has conducted daily health information management during the Ebola outbreaks in Equator and North Kivu since May 2018. Activities include epidemiological monitoring and analysis, GIS mapping of cases, Monitoring and Evaluation, information products, as well as ongoing support for partner, donor and media briefings. Until the end of 2018, this activity that is embedded in the Incident Management System (IMS) in accordance with ERF procedures will have been sustained for more than 2055 days full day-equivalent for up to 13 staff members plus 30 external partners in 2018.

- In 2018, at the request of the Director-General, the IHR Secretariat convened the Emergency Committee under the IHR for 3 events: the Ebola outbreak in Équateur, DRC in May 2018, Ebola outbreak in North Kivu, DRC in October 2018, and international spread of Polio in February, May and August 2018.

- IHR Secretariat has monitored international travel and trade measures for several events in 2018, and supported States Parties to improve compliance with the IHR requirements under Article 43 regarding the additional health measures related to international travel and trade: MERS-CoV in the Republic of Korea, Nipah India, Ebola Democratic Republic of the Congo, Rift Valley Fever Kenya, Cholera, Zimbabwe.

- WHO activated the Incident Management System (IMS), in accordance with ERF procedures for 100% of Grade 3 emergencies, to fulfill its six critical functions and scaled up its operational and technical support to immediately address health needs and risks of the affected population. The Grade 3 emergencies in the Syrian Arab Republic and Yemen are also Inter-Agency Standing Committee (IASC) system-wide Level 3 emergencies.

- Between 1 January and 31 December 2018, WHO responded to 62 graded emergencies in 48 countries. Between 1 January and 1 March 2019, WHO is responding to 38 graded emergencies in 32 countries. From the acute emergencies, 8 were classified Grade 3 emergencies as the highest severity level based on the WHO’s Emergency Response Framework (ERF), requiring major/maximal organization-wide support (beyond the Emergencies Programme and across regions and countries). Responses have also leveraged key support from partners through the Global Outbreak Alert and Response Network (GOARN), on the ground and through strategic collaborations.

- For 2018, the total number of deployments was 1,980 with 189 administrative staff deployed. To date in 2019, there have been 260 deployments, including 38 administrative staff. The DRC North Kivu Ebola response alone has deployed over 30,000 combined person days thus far.

- The ongoing DRC North Kivu and Ituri Ebola outbreak is an example of WHO’s effective field operations this year: Over 700 people have been deployed to the field for operational and technical support, both WHO staff/consultants and through GOARN partners. Since 1 August 2018 $5.5 million worth of supplies have been mobilized to DRC. This has included 253 international shipments, measuring 311 tons. Beyond key operational necessities such as ambulances, PPE, IPC kits, syringes, freezers and other logistical requirements, WHO has also led the implementation of expanded access/compassionate use of an investigational Ebola vaccine (to over 85,000 people) and the administration of four investigational therapeutics for Ebola (to over 400 people to date, including enrolment in a randomized control trial). This complex operation exemplifies the increasing operational capacity of WHO and the leadership role it is playing in responding to acute health emergencies.

- In Bangladesh, WHO lead and coordinated the health sector response, in close collaboration with the Ministry of Health. A cholera outbreak was averted, due to early prioritization of oral cholera vaccination campaign and progressive expansion of health services achieved. Sphere standards were met for mortality (0.2 deaths/10,000 day) and outpatient consultations (3.1 new consultations/person/year). A public health catastrophe was averted, despite high risks.

- In Northern Nigeria Sphere standards mortality rates were progressively reduced and remained below the emergency threshold. Progressive expansion of health services in a difficult operating environment resulted in Sphere standards being met (1.1 new consultations/person/year).

- In Syria, outbreaks of vaccine-derived polio (cVDPV2) were effectively controlled, in Raqqa and Deir Ez Zoor governorates despite extremely difficult operating environments. WHO and partners responded flexibly and effectively to multiple emergencies and hotspots in the Northeast, Raqqa, Eastern Ghouta, Northwest, and Southwest. A revitalized Whole of Syria approach strengthened the response.

- In Syria, outbreaks of bloody diarrhea and Hepatitis A were successfully controlled, and significant progress made on provision medicines to treat Leishmaniasis.

- In Syria, WHO responded to acute deteriorations of the protracted crisis in several events in 2018, which saw an intensification of the violence in the first two quarters of the year. WHO scaled up significantly its presence and response in NE and NW Syria, especially on trauma management, medical evacuations, strengthening the referral network for trauma management and setting up WHO PHC referral networks for the response in NW Syria. Responded to public health consequences of alleged chemical events within the IHR framework, referral pathways and in ensure treatment and care. Access to health care was increased cross line and cross border where security situation and restrictions allowed unimpeded access. WHO advocated for the lifting of restrictions on importation of internationally procured medicines for humanitarian response and obtained the lifting of restrictions in early 2018. This allowed provision of medicines especially for NCDs and dialysis treatments in a more predictable way.
• In Yemen, WHO supports 202 health facilities, including all 22 governorate hospitals, to deliver essential health services. Support includes essential medicines, training, equipment, fuel and monitoring. OCV campaigns in high risk districts have contributed to reduction in cholera cases compared to previous period last year, and further campaigns will continue.

• For the DRC Kivu Ebola and DRC Equator Ebola responses, standard weekly external situation reports are disseminated on the AFRO website and daily internal situation reports are disseminated to the IMST at three levels.

• For the Zimbabwe Cholera response (2018), daily internal situation reports were disseminated to the IMST at three levels.

• For the Nigeria Lassa Fever response (2018), weekly situation reports were disseminated to the IMST at three levels.

• A revitalized Whole of Syria approach strengthened the response. The Whole of Syria response structure from four hubs incl cross border service delivery was adapted to contingency planning scenarios and evolution of the overall situation. The Amman hub was closed end of the year and staff absorbed to other functions within the response set up. Continuous revision of contingency plans and operational plans allowed scalable and swift WHO response to ever changing scenarios and a very fluid situation in 2018.

• For the response to the Ebola outbreak in North Kivu, senior liaisons from UNICEF and IFRC were seconded through WHO’s Incident Management team in headquarters to enhance collaboration and effectively implement risk communication and community engagement in the country. Weekly coordination calls are held with partners (including NGOs and academic institutions) at the global level, and WHO teams support daily meetings of the risk communication, community engagement and social mobilization commission led by the Ministry of Health at the local level.

• WHO also works closely with GOARN social science research partners in deploying social science knowledge and interventions for better understanding of the community in the response, including in the context of the introduction of investigational vaccines and therapeutics.

• In 2018, a total of 90 Risk Communication officers were deployed as part of the IMS for 10 emergencies. In 2019, there have been 7 new deployments for risk communication for 1 incident (DRC Ebola).

• The IHR Secretariat is providing technical support and partner coordination for cross-border and travel measures at Points of Entry for the response to the Ebola outbreak in DRC. Travel advice has been published on the ITH website for Yellow Fever, Ebola, MERS-CoV, and Cholera.

• Essential health services and systems maintained in fragile, conflict and vulnerable settings; working jointly between WHE and HIS
  o Joint work: Operationalizing WHO’s support for Universal Health Coverage in Fragile, Conflict-affected and Vulnerable (FCV) Settings document finalized and the SOP for UHC Joint Working Team was finalised.
  o The Emergencies Programme and the Universal Health Care Programme agreed to focus comprehensive and sustained joint work in four crises in order to develop approaches that tailor the response to long term recurrent needs in volatile settings, increasingly integrating the pillars of the health system in the response, to foster resilience and a more robust response. Those efforts will translate not only on country support but on tested guidance that can be applied to other settings.
  o For Nigeria: An operational review that shifted the response planning towards HDN (while keeping the dynamic lifesaving aspects), a detailed monitoring framework, fortnightly TCs, work with different health systems pillars in HQ for exploring ways of support.
  o UHC2030 Advocacy Briefing on UHC in Fragile Settings drafted to inform the broader UHC high level meeting and its outcome document next year.
  o Specific examples: In Yemen, WHO and the World Bank have partnered to equip 72 hospitals with the Minimum Service Package (MSP). In Bangladesh, WHO has made significant contributions to infectious disease and outbreak control, expansion of and support to health services, capacity building of the national health system, and coordination of the health sector response. Coverage of health services meets international Sphere standards. In Nigeria, WHO has increase provision of health services through mobile teams, CORPS/CHW treatment for severely ill malnourished children, Malaria SMC, and health network expansion. In North-East Syria, trauma care referral pathways and the blood bank system were strengthened, as well as undertaking health facility resource assessments. Provisioned healthcare in displacement camps and provided support to the health system.

In Syria, monitored availability and functionality of health services through quarterly HeRAMs, and adapted WHO response and partner response to maintain essential services running for 12.3 M people incl an increasing number of displaced and affected host populations, incl through a high number of mobile clinics supported by WHO and health partners, to increase flexibility and access. Access to health services was expanded where security allowed in Q3 and Q4.